Swedish and Providence Form Special Team To Improve Patient Care During Critical Transitions Between Hospital and Skilled Nursing Facilities

By Cynthia Flash

The transition between acute care in a hospital setting and rehabilitation care in a skilled nursing facility can be wrought with problems as records are misplaced, medications fail to transfer and orders are lost in translation.

In an effort to improve these transitions, Swedish Medical Center—with its affiliation with Providence Health & Services—has developed a new Residential Care Team to partner with four skilled nursing facilities that offer transitional care to patients.

"The responsibility of the hospital to take care of patients does not end at discharge from the hospital," said Dr. Jon Younger, Medical Director of Continuum of Care with the Swedish Residential Care Team. "It's at the transition of care where true excellence happens or disasters occur. It's handoffs from one side to another where errors are made, where patient and family satisfaction suffers. One of the most critical points of transition is from the hospital to a nursing facility for short-term rehabilitation. We've created this Residential Care Team to try and make that transition easier."

The team's goal is to improve patient care and family satisfaction, reduce costs, and decrease unnecessary hospital readmissions. This new system of more closely monitoring patients as they transition from the hospital to short-term rehabilitation is especially important now because hospitals will be penalized for excessive readmissions. Nearly one-fifth of Medicare beneficiaries, about 2 million per year nationally, end up back in the hospital within 30 days of discharge, according to the Medicare Payment Advisory Commission. On Oct. 1, 2012, the Centers for Medicaid and Medicare Services (CMS) started penalizing hospitals for high readmission rates. Reducing readmissions and improving care coordination are also major components of the Affordable Care Act.

"Post-acute services are extremely important to avoid hospital readmission and ensure a successful transition," said Charlene Boyd, Vice President for Skilled and Assisted Living at Providence Health & Services, which has two skilled nursing facilities offering transitional care in King County that are partnering with Swedish. "It's so important to make that as predictable and as smooth and as patient-directed as possible. We want to partner to continually improve quality outcomes."

Younger said the team aims to make sure patients' care is well coordinated, that communication is excellent between care providers in different settings, that patients receive seamless care between care settings and that care plans are consistent and followed.

The Residential Care Team will make sure any patient issues or complications from the hospital are known in the skilled nursing facility. It will know exactly what medications the patient was given in the hospital and exactly what treatments were ordered for the patient.

In June, the Swedish Residential Care Team started working with Providence Mount St. Vincent in West Seattle, Providence Marianwood in Issaquah, The Caroline Kline Galland Home in south Seattle, and Bethany at Silver Lake in Everett.

Before a patient leaves a Swedish hospital or once the patient enters the skilled nursing facility for rehabilitation, a doctor sees the patient and completes an assessment. "It doesn't matter who the primary care physician is affiliated with," Younger said. "We do discharge summaries, which we communicate back to the specialty physicians and primary care doctors through the patients' electronic health record."

Swedish and Providence have both invested in a consistent electronic health record—the Epic system. The result is that it is easier to share medical records during this transition, medical issues and complications are identified and communicated, medications are known, lab tests and information from specialists are accessible and treatments that are ordered are known.

The Epic system is becoming a community standard. If primary care physicians use Epic, it connects the system with the hospital. "But if not we make sure we communicate with them and make sure they get a discharge summary from the facility," Younger said.

The Swedish Residential Care Team of doctors and nurses is assigned to follow patients discharged from Swedish to the
After transitioning from Swedish and spending more than two months receiving occupational and physical therapy at The Mount, Penny Phelps was in good spirits and happy with the care she received. “Both places I really enjoyed. Swedish is a wonderful hospital and by the time I leave, I have the names of all the people who have been nurses to me. I like to make friends with whoever is coming into my room so it comes to the point where you say, oh no, I have to leave all my friends. Both places I really have enjoyed and have enjoyed the staff. I really can’t complain.”

In late January, Phelps said of her experience at The Mount, “The people are so nice here. I feel like it’s like my little family.

“They seem to work hand in hand,” she said of her medical providers. “Whenever I would go to my orthopedic doctor, The Mount floor nurse would send a packet that I would take with me to show them what I was on at the time. At the nurse’s station, they have computers and I know that the physical therapist and occupational therapists have computers.”

Elizabeth Pockrus, another former Swedish patient who received transitional rehabilitation care from Providence Mount St. Vincent, also was happy with her care at both facilities. After suffering from medical complications for several years—including a dropped foot and stiff hands—she learned in December that she would need emergency neck surgery. She underwent surgery Jan. 3 at Swedish and moved to The Mount for transitional care on Jan. 18. “One day I was living the good life and the next day I was out,” said Pockrus, age 63. “Everyone here has been helping me. At first I was really weak; I couldn’t get out of bed. Each day I just forced myself. Now I’m getting out of bed every morning. They’re helping me get dressed. I’m getting up and sitting in the wheel chair to eat.”
Pockrus received physical therapy two or three times a day and planned to move home for a while before undergoing another round of surgery on her back.

She said the transition from the hospital to The Mount was seamless. "I went there with a transport vehicle. They wheeled me in and went right to my room and gave me dinner the first night. They had everything right there." She said she saw a doctor from Swedish and the staff at The Mount gave her everything the doctor ordered.

That's what Providence's Boyd likes to hear. "Our seamless process is extremely important for the medical and therapy needs of patients for stabilization," she said. "We're miles ahead of other community care settings because of our consistent quality initiatives."

Transitions out of skilled nursing facilities and back into patients' home setting is another critical transition that Swedish and Providence are working to coordinate—to make sure the patient gets the right services in the right place at the right time, and that information is communicated back to the patient's primary care doctor, Younger said.

The Residential Care Team is an example of the future of healthcare transitions—where providers work closely together to ease patients' way as they move from one level of care to the next. Providence is working with Swedish to lead the way in care transitions to skilled nursing facilities and is also working with the many other hospital providers in the areas of home health, hospice, home infusion and other community-based services, Boyd said.

"The advantage of Providence is that we have begun to connect many care settings from acute to post-acute services to home and community," she said.

Eventually, Younger said, Swedish hopes to grow the team so that it would also see patients in assisted living, nursing home custodial care, independent living and adult family homes. "Ultimately we'd like to have a geriatric service that follows people wherever they live and need care."

About the Author
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